

OXFORD PUBLIC SCHOOLS

Project COFFEE

**FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I authorize staff of the Oxford Public Schools and Project COFFEE who are trained in the basics of first aid/CPR to give my child first aid/CPR when appropriate.

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the program to transport my child to the nearest medical care facility and/or to \_\_\_\_\_, and to secure necessary medical treatment for my child.

Child's Physician Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Child's Allergies: \_\_\_\_\_

Chronic Health Conditions: \_\_\_\_\_

Emergency Contacts (In order to be contacted)

Name \_\_\_\_\_

Address \_\_\_\_\_

Relationship to child \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Do you give permission for child to be released to this person? Yes \_\_\_\_\_ No \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Relationship to child \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Do you give permission for child to be released to this person? Yes \_\_\_\_\_ No \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Relationship to child \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Do you give permission for child to be released to this person? Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_  
Parent /Guardian Signature Date (valid for one year)

Health Insurance Coverage \_\_\_\_\_ Policy # \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone \_\_\_\_\_

Cell \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone \_\_\_\_\_

Cell \_\_\_\_\_